SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Medicaid Presumptive Eligibility

PRIORITY PROCESSING
This is not a full Medicaid application

things to know

Who is authorized to complete this application?

- Hospitals have the option to perform Presumptive Eligibility (PE) determinations for select Medicaid coverage as granted by the Affordable Care Act.
- An employee of an authorized hospital may use this application to conduct an eligibility determination on a potentially Medicaid-eligible applicant. Only those employees who have been trained by Healthy Connections are allowed to conduct an eligibility determination.
- To participate in the PE program, hospitals must (i) participate in Medicaid and (ii) not be disqualified. Presumptive eligibility determinations must be performed by a hospital employee, and authority may not be delegated to any non-employee, including employees of affiliated entities.

Who is eligible for this program?

An individual receiving hospital services or community member who does not have insurance coverage, but who, based on their self-reported income and circumstances, may be eligible for Medicaid coverage.

Presumptive Eligibility may only be applied to the following Medicaid categories:

- Children under Age 19 (PHC)
- Parents and Caretaker Relatives (PCR)
- Former Foster Care (FFC) Children to Age 26
- Breast and Cervical Cancer Treatment Program (BCCP)
- Healthy Connections Checkup*
- Pregnant Women (PW) **

* *Checkup category does not provide full Medicaid benefits.*
** *PW is limited to ambulatory prenatal care and does not include labor and delivery.*

Where can I find resources to help complete this application?

- Visit **scdhhs.gov** and read our Frequently Asked Questions.
- Call the Provider Service Center at (888) 289-0709 to speak to a representative.
- Check out this online resource: **http://medicaidelearning.com**.

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Notice of Non-Discrimination

The South Carolina Department of Health and Human Services (SCDHHS) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. SCDHHS does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

SCDHHS provides free aids and services to people with disabilities, such as qualified sign language interpreters and written information in other formats (large print, braille, audio, accessible electronic formats, other formats). We provide free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact Janet Bell, ADA and Civil Rights Official, by mail at: PO Box 8206, Columbia, SC 29202-8206; by phone at: 1-888-549-0820 (TTY: 1-888-842-3620); or by email at: civilrights@scdhhs.gov.

If you believe that SCDHHS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Civil Rights Official using the contact information provided above. You can file a grievance in person or by mail or email. If you need help filing a grievance, we are available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201 or by phone at: 800-368- 1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Language Services

If your primary language is not English, language assistance services are available to you, free of charge. Call: 1-888-549-0820 (TTY: 1-888-842-3620).

si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-549-0820 (TTY: 1-888-842-3620).

أذا كانت لغتك الاساسية غير اللغة الانكليزية فان خدمات المساعدات اللغوية متوفرة لك مجانا.اتصل على الرقم:

888-549-0280(رقم هاتف الصم والبكم 1-888-842-3620)

Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-888-549-0820 (TTY: 1-888-842-3620).

Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-549-0820 (телетайп: 1-888-842-3620).

Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-549-0820 (TTY: 1-888-842-3620).

Se você fala português do Brasil, os serviços de assistência em sua lingua estão disponíveis para você de forma gratuita. Chame 1-888-549-0820 (TTY : 1-888-842-3620)

如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-888-549-0820 (TTY: 1-888-842-3620)

Falam tawng thiam tu na si le tawng let nak asi mi 1-888-549-0820 (TTY: 1-888-842-3620) ah tang ka pek tul lo in na ko thei.

धयद आप हदी बोलते ह तो आपके िलए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह। 1-888-549-0820 (TTY: 1-888-842- 3620) पर कॉल कर।

한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-549-0820 (TTY: 1-888-842-3620)번으로 전화해 주십시오.

Haka tawng thiam tu na si le tawng let asi mi 1-888-549-0820 (TTY: 1-888-842-3620) ah tang ka pek tul lo in ko thei.

Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 888-549-0820 (ATS : 888-842-3620).

နမ့်ကတိၤ ကညီ ကျိာ်အဃိ, နမၤန့်၊ ကျိာ်အတၱ်မၤစၢၤလၢ တလာ်ဘူဉ်လၢာ်စ့ၤ နီတမံၤဘဉ်သ့နှဉ်လီၤ. ကိး 888-549-0820 (TTY: 888-842-3620)

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-888-549-0820 (መስማት ለተሳናቸው: 1-888-842-3620).

အကယ်၍ သင်သည် မြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့် င့်အတွက် စီစဉ်ဆောင်ရွက်ပေးပါမည်။ ဖုန်းနံပါတ် 888-549-0820 (TTY: 888-842-3620) သို့ ခေါ် ဆိုပါ။

PRIORITY PROCESSING
This is not a full Medicaid application

STEP 1: PERSON 1 Tell us about the individual.

PRESUMPTIVE ELIGIBILITY

All fields on this form are required unless noted as optional.

1. First name, middle name, last name and suffix			2. Relationship to PERSON 1 **SELF**
3. Date of birth (mm/dd/yyyy)	4. Sex: ☐ Male ☐ Female	5. Social Security Number (Optional)	
6. Home address (Leave blank if you don't have one.)			7. Apartment or suite number
8. City	9. State	10. ZIP code	11. County
12. Mailing address (if different from home address)			13. Apartment or suite number
14. City	15. State	16. ZIP code	17. County
18. Phone number (Leave blank if you don't have one.)	19. E-mail address (Leave blank if you don't have one)		

20. Does the applicant need health coverage? If "No", go to question 28. ☐ Yes ☐ No

21. Do you want to apply for Family Planning benefits? ☐ Yes ☐ No

Family Planning is a limited benefit program, which provides family planning services, family planning-related services and certain limited preventative screenings. Family Planning is not full Medicaid coverage. If you leave this question blank, we will not assess you for Family Planning.

22. Is the applicant a resident of South Carolina? ☐ Yes ☐ No

23. a.Is the applicant a US citizen? (Born in U.S.; child of U.S. citizen; or former alien now naturalized as a U.S. citizen) ☐ Yes ☐ No

b.Is the applicant a US national? (Born in unincorporated U.S. Territory who elects to be a national, not a U.S. citizen) ☐ Yes ☐ No

c. If no, is the applicant a qualified alien? ☐ Yes ☐ No

24. Is the applicant pregnant? ☐ Yes ☐ No

a. If yes, how many babies are expected? _____ b. What is the due date? _____

Note: PE coverage for pregnant women is limited to ambulatory prenatal care. It does not cover labor and delivery. Healthy Connections will follow up with the individual to apply for further coverage.

25. Is this person a parent or caretaker relative? ☐ Yes ☐ No

26. Has the applicant been diagnosed with / receiving treatment for any of the following? ☐ Yes ☐ No

• Breast Cancer • Cervical Cancer • Atypical Breast Hyperplasia • Precancerous Cervical Lesion (CIN 2/3)

27. Was the applicant enrolled in Medicaid and in foster care in South Carolina at age 18 or older? ☐ Yes ☐ No

28. INCOME (Write the total income before taxes are taken out.) **Do not leave this field blank.**

▼ Job income *For example, wages, salaries, and self-employment income.*

Amount **$** _____ How often? (check one) ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Yearly

▼ Other income For example, unemployment checks, alimony, or disability payments from the Social Security Administration (SSDI). Do not include Supplemental Security Income (SSI) or any child support you receive.

Amount **$** _____ How often? (check one) ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Yearly

PRIORITY PROCESSING
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STEP 1: PERSON 2

Tell us about the individual's family.

PRESUMPTIVE ELIGIBILITY

Include family members who live with the, including the individual's spouse/partner and children under 19. If the applicant is under 19, include the applicant's spouse/partner, children, parents and siblings.

All fields on this form are required unless noted as optional.

1. First name, middle name, last name and suffix			2. Relationship to PERSON 1
3. Date of birth (mm/dd/yyyy)	4. Sex: ☐ Male ☐ Female	5. Social Security Number (Optional)	
6. Home address (Leave blank if you don't have one.)			7. Apartment or suite number
8. City	9. State	10. ZIP code	11. County
12. Mailing address (if different from home address)			13. Apartment or suite number
14. City	15. State	16. ZIP code	17. County
18. Phone number (Leave blank if you don't have one.)	19. E-mail address (Leave blank if you don't have one)		

20. Does the applicant need health coverage? If "No", go to question 28. ☐ Yes ☐ No

21. Do you want to apply for Family Planning benefits? ☐ Yes ☐ No

Family Planning is a limited benefit program, which provides family planning services, family planning-related services and certain limited preventative screenings. Family Planning is not full Medicaid coverage. If you leave this question blank, we will not assess you for Family Planning.

22. Is the applicant a resident of South Carolina? ☐ Yes ☐ No

23. a.Is the applicant a US citizen? (Born in U.S.; child of U.S. citizen; or former alien now naturalized as a U.S. citizen) ☐ Yes ☐ No

b.Is the applicant a US national? (Born in unincorporated U.S. Territory who elects to be a national, not a U.S. citizen) ☐ Yes ☐ No

c. If no, is the applicant a qualified alien? ☐ Yes ☐ No

24. Is the applicant pregnant? ☐ Yes ☐ No

a. If yes, how many babies are expected? _____ b. What is the due date? _____

Note: PE coverage for pregnant women is limited to ambulatory prenatal care. It does not cover labor and delivery. Healthy Connections will follow up with the individual to apply for further coverage.

25. Is this person a parent or caretaker relative? ☐ Yes ☐ No

26. Has the applicant been diagnosed with / receiving treatment for any of the following? ☐ Yes ☐ No

• Breast Cancer • Cervical Cancer • Atypical Breast Hyperplasia • Precancerous Cervical Lesion (CIN 2/3)

27. Was the applicant enrolled in Medicaid and in foster care in South Carolina at age 18 or older? ☐ Yes ☐ No

28. INCOME (Write the total income before taxes are taken out.) **Do not leave this field blank.**

▼ Job income *For example, wages, salaries, and self-employment income.*

Amount **$** _____ How often? (check one) ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Yearly

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Amount **$** _____ How often? (check one) ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Yearly

PRIORITY PROCESSING
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STEP 1: PERSON 3

Tell us about the individual's family.

PRESUMPTIVE ELIGIBILITY

Include family members who live with the, including the individual's spouse/partner and children under 19. If the applicant is under 19, include the applicant's spouse/partner, children, parents and siblings.

All fields on this form are required unless noted as optional.

1. First name, middle name, last name and suffix			2. Relationship to PERSON 1
3. Date of birth (mm/dd/yyyy)	4. Sex: ☐ Male ☐ Female	5. Social Security Number (Optional)	
6. Home address (Leave blank if you don't have one.)			7. Apartment or suite number
8. City	9. State	10. ZIP code	11. County
12. Mailing address (if different from home address)			13. Apartment or suite number
14. City	15. State	16. ZIP code	17. County
18. Phone number (Leave blank if you don't have one.)		19. E-mail address (Leave blank if you don't have one)	

20. Does the applicant need health coverage? If "No", go to question 28. ☐ Yes ☐ No

21. Do you want to apply for Family Planning benefits? ☐ Yes ☐ No

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22. Is the applicant a resident of South Carolina? ☐ Yes ☐ No

23. a.Is the applicant a US citizen? (Born in U.S.; child of U.S. citizen; or former alien now naturalized as a U.S. citizen) ☐ Yes ☐ No

b.Is the applicant a US national? (Born in unincorporated U.S. Territory who elects to be a national, not a U.S. citizen) ☐ Yes ☐ No

c. If no, is the applicant a qualified alien? ☐ Yes ☐ No

24. Is the applicant pregnant? ☐ Yes ☐ No

a. If yes, how many babies are expected? _____ b. What is the due date? _____

Note: PE coverage for pregnant women is limited to ambulatory prenatal care. It does not cover labor and delivery. Healthy Connections will follow up with the individual to apply for further coverage.

25. Is this person a parent or caretaker relative? ☐ Yes ☐ No

26. Has the applicant been diagnosed with / receiving treatment for any of the following? ☐ Yes ☐ No

• Breast Cancer • Cervical Cancer • Atypical Breast Hyperplasia • Precancerous Cervical Lesion (CIN 2/3)

27. Was the applicant enrolled in Medicaid and in foster care in South Carolina at age 18 or older? ☐ Yes ☐ No

28. INCOME (Write the total income before taxes are taken out.) **Do not leave this field blank.**

▼ Job income *For example, wages, salaries, and self-employment income.*

Amount **$** _____ How often? (check one) ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Yearly

▼ Other income For example, unemployment checks, alimony, or disability payments from the Social Security Administration (SSDI). Do not include Supplemental Security Income (SSI) or any child support you receive.

Amount **$** _____ How often? (check one) ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Yearly

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STEP 1: PERSON 4

Tell us about the individual's family.

PRESUMPTIVE ELIGIBILITY

Include family members who live with the, including the individual's spouse/partner and children under 19. If the applicant is under 19, include the applicant's spouse/partner, children, parents and siblings.

1. First name, middle name, last name and suffix			2. Relationship to PERSON 1
3. Date of birth (mm/dd/yyyy)	4. Sex: ☐ Male ☐ Female	5. Social Security Number (Optional)	
6. Home address (Leave blank if you don't have one.)			7. Apartment or suite number
8. City	9. State	10. ZIP code	11. County
12. Mailing address (if different from home address)			13. Apartment or suite number
14. City	15. State	16. ZIP code	17. County
18. Phone number (Leave blank if you don't have one.)	19. E-mail address (Leave blank if you don't have one)		

20. Does the applicant need health coverage? If "No", go to question 28. ☐ Yes ☐ No

21. Do you want to apply for Family Planning benefits? ☐ Yes ☐ No

Family Planning is a limited benefit program, which provides family planning services, family planning-related services and certain limited preventative screenings. Family Planning is not full Medicaid coverage. If you leave this question blank, we will not assess you for Family Planning.

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23. a.Is the applicant a US citizen? (Born in U.S.; child of U.S. citizen; or former alien now naturalized as a U.S. citizen) ☐ Yes ☐ No

b.Is the applicant a US national? (Born in unincorporated U.S. Territory who elects to be a national, not a U.S. citizen) ☐ Yes ☐ No

c. If no, is the applicant a qualified alien? ☐ Yes ☐ No

24. Is the applicant pregnant? ☐ Yes ☐ No

a. If yes, how many babies are expected? _____ b. What is the due date? _____

Note: PE coverage for pregnant women is limited to ambulatory prenatal care. It does not cover labor and delivery. Healthy Connections will follow up with the individual to apply for further coverage.

25. Is this person a parent or caretaker relative? ☐ Yes ☐ No

26. Has the applicant been diagnosed with / receiving treatment for any of the following? ☐ Yes ☐ No

• Breast Cancer • Cervical Cancer • Atypical Breast Hyperplasia • Precancerous Cervical Lesion (CIN 2/3)

27. Was the applicant enrolled in Medicaid and in foster care in South Carolina at age 18 or older? ☐ Yes ☐ No

28. INCOME (Write the total income before taxes are taken out.) **Do not leave this field blank.**

▼ Job income *For example, wages, salaries, and self-employment income.*

Amount **$** _____ How often? (check one) ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Yearly

▼ Other income For example, unemployment checks, alimony, or disability payments from the Social Security Administration (SSDI). Do not include Supplemental Security Income (SSI) or any child support you receive.

Amount **$** _____ How often? (check one) ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Yearly

If you have more people to add, complete this form for each additional person.

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STEP 2 Sign this application

PRESUMPTIVE ELIGIBILITY

▶ Signature of applicant/individual listed in Step 1 (Optional)	Date (mm/dd/yyyy)

STEP 3 Return the completed application.

PRESUMPTIVE ELIGIBILITY

Mail your signed application to:

SCDHHS
PO Box 100101
Columbia SC 29202-3101

–OR–

Fax your signed application to:

(803) 255-8253

If you want to register to vote, you can complete a voter registration form at **scvotes.org**.